CAMPER HEALTH HISTORY FORM

Instructions for completing all medical forms:

1. Complete pages 1, 2 & 3 and make a copy
2. Send the original form to Camp by February 28, 2017
3. Have the physician complete and sign the Physician Statement and fax the completed form to 904-230-7465. Include Procedure and Treatment form as needed.

CAMPER NAME:____BIRTH DATE:_____________________

FIRST MIDDLE LAST MONTH/DATE/YEAR

CAMPER HOME ADDRESS:____

STREET ADDRESS CITY STATE ZIP CODE

PARENT/GUARDIAN WITH LEGAL CUSTODY TO BE CONTACTED IN CASE OF INJURY OR ILLNESS:

NAME:_________________________ RELATIONSHIP TO CAMPER:________________PREFERRED PHONES:(___)____________ (___)___________

HOME ADDRESS:____

STREET ADDRESS CITY STATE ZIP CODE

ADDITIONAL CONTACT IN EVENT PARENTS/GUARDIANS CAN'T BE REACHED:

NAME:_______________________ RELATIONSHIP TO CAMPER:________________PREFERRED PHONES:(__)_____________ (___)

ALLERGIES: ☐No known allergies ☐ This camper is allergic to: ☐Food ☐ Medicine ☐The environment (insect stings, hay fever, etc) (Please describe below what the camper is allergic to and the reaction seen.)

DIET, NUTRITION: ☐ This camper eats a regular diet ☐ This camper eats a regular vegetarian diet
☐ This camper has special food needs **(Please describe dietary needs below)**

RESTRICTIONS: ☐ I have reviewed the program and activities of Camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of Camp and feel the camper can participate with the following restrictions or adaptations. **(Please describe below)**

GENERAL HEALTH HISTORY: Check yes or no for each statement. Explain 'yes' answers below.

1. Ever been hospitalized? ....☐Yes ☐No
2. Ever had surgery? ....☐Yes ☐No
3. Have recurrent/chronic illness?.........................☐Yes ☐No
4. Had a recent infectious disease? ....☐Yes ☐No
5. Had a recent injury? ....☐Yes ☐No
6. Had asthma/wheezing/shortness of breath? ....☐Yes ☐No
7. Have diabetes? ....☐Yes ☐No
8. Had seizures? ....☐Yes ☐No
9. Had headaches? ....☐Yes ☐No
10. Wear glasses, contacts or protective eyewear?.☐Yes ☐No
11. Had fainting of dizziness? ....☐Yes ☐No
12. Passed out/had chest pain during exercise? ....☐Yes ☐No
13. Had mononucleosis ("mono") during the past 12 months?☐Yes ☐No
14. If female, have problems with periods/menstruation? .....☐Yes ☐No
15. Have problems with falling asleep/sleepwalking? ....☐Yes ☐No
16. Ever had back/joint problems? ....☐Yes ☐No
17. Have a history of bedwetting? ....☐Yes ☐No
18. Have problems with diarrhea/constipation? ....☐Yes ☐No
19. Have any skin problems? ....☐Yes ☐No
20. Traveled outside the country in the past 9 months? ....☐Yes ☐No

Please explain all "yes" answers in the space below, noting the number of questions. For the travel outside the country, please name countries visited and dates of travel.

MENTAL, EMOTIONAL AND SOCIAL HEALTH: Check "yes" or "no" for each statement.

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?... ☐Yes ☐No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.. ☐Yes ☐No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?... ☐Yes ☐No
4. Had a significant life event that continues to affect the camper's life?... ☐Yes ☐No
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) **Please explain "yes" answers in the space below, noting the number of the questions.** Camp may contact you for additional information.

CAMPER HEALTH HISTORY FORM

CAMPER NAME:____ Birth Date:______________________
FIRST MIDDLE LAST MONTH/DATE/YEAR

IMMUNIZATION HISTORY: Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form. Campers over the age of 18 may not be able to obtainthe shot record however the date of Tetanus booster must be documented on this form.

IMMUNIZATION	DOSE 1 MONTH/YEAR	DOSE 2 MONTH/YEAR	DOSE 3 MONTH/YEAR	DOSE 4 MONTH/YEAR	DOSE 5 MONTH/YEAR	MOST RECENT DOSE;MONTH/YEAR
Diptheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio* (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐Had chicken pox. Date:___________						
Meningococcal meningitis (MCV4)						

TUBERCULOSIS (TB) TEST: DATE:____________________ ☐NEGATIVE ☐POSITIVE

If your camper has not been fully immunized, please sign the following statement. I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian:____Date:____________________________Relationship to Camper:_______________

WHAT HAVE WE FORGOTTEN TO ASK? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permissions to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I giver permisssion to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian:____Date:____________________Relationship to Camper:___________

If for religious or other reasons you cannot sign this, contact Camp for a legal waiver which must be signed for attendance.

CAMPER HEALTH HISTORY FORM

CAMPER NAME:____ Birth Date:______________________
FIRST MIDDLE LAST MONTH/DATE/YEAR

MEDICATION: ☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medicaiton(s) while at camp.

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamens & natural remedies. Prescription medication must come in original container with original label. Over the counter medication should come in individual, labeled containers but does not have to be in original container. Provide enough of each medication to last 2 extra days.

Name of medication	Date started	Reason for taking it	When is it given	Amount or dose given	How it is given
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:		
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			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		